CITY OF MARINA

EMPLOYEE BENEFITS GUIDE

2023 PLAN YEAR

OPEN ENROLLMENT

September 19, 2022 through October 14, 2022

RGS Regional Government Services

SERVING PUBLIC AGENCIES SINCE 2002

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WELCOME TO THE CITY OF MARINA

At the City of Marina, we value your contributions to our success and want to provide you with a benefits package that protects your health and helps your financial security, now and in the future. We continually look for valuable benefits that support your needs, whether you are single, married, raising a family, or thinking ahead to retirement. We are committed to giving you the resources you need to understand your options and how your choices could affect you financially.

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

The purpose of this booklet is to help you select benefit options during the 2022 Annual Open Enrollment period. It highlights the options available to you and the steps you need to take during the open enrollment period. After you are acquainted with what the City has to offer you and your family, and if you have (1) changes to your medical, dental or vision plans, or (2) wish to enroll in the City's FSA accounts or (3) purchase additional supplemental life insurance, you may complete the applicable enrollment form(s) located on the City's Benefit Page. Click **HERE** for more information.

What's New This Year!

For easier access, this year you can access all detailed Open Enrollment information from home or the office by clicking on the City's Benefits page at https://www.cityofmarina/239/Benefits. There you can view your benefits options, premium costs, medical, dental, vision, Flexible Spending Account information, benefit plan summaries, complete and download enrollment change forms and email them to the Human Resources Department at benefits@srcityofmarina.org.

Action	Form to Use	Submit To	Deadline
Enroll or change your medical plan, add or remove dependents, or drop your coverage	*Benefits Election Form* Fillable form - Easy to use	benefits@cityofmarina.org	10/14/2022
Enroll in 2023 Flexible Spending Accounts (Health and/or Dependent Care)	*Flexible Spending Form*	benefits@cityofmarina.org	10/14/2022
Enroll in voluntary life & AD&D insurance	*Standard Life Enrollment Form*	benefits@cityofmarina.org	10/14/2022

Forms can also be mailed or personally dropped off at Human Resources—Benefits, City of Marina 211 Hillcrest Avenue, Marina, CA 93933

OPEN ENROLLMENT: HOW TO ENROLL IN AND MAKE CHANGES TO YOUR BENEFITS

What Is Open Enrollment?

Open enrollment is the **only time** you can make changes to your health benefit elections, unless you have a "qualifying life event". That means once you have made your elections during the Open Enrollment period, in accordance with law, no changes can be made unless you have a "*qualifying/life changing event*" such as marriage, divorce, birth, adoption or a change in your employment status that results in a change to the benefits available to you. The elections you make during this year's Open Enrollment period will go into effect **on January 1, 2023.**

Actions To Take During Open Enrollment.

⇒ Learn about your health benefit options by reading this Benefits Guide.

⇒ To make benefit changes for 2023, you may do so by completing the applicable forms (health, flexible spending or life insurance enrollment forms) located on the City's Benefits webpage at, https://www.cityofmarina.org/239/Benefits.

⇒ To enroll in a Flexible Spending Account (Health and/or Dependent Care), you must complete the FSA form located on the City's benefit website. Enrollments from 2022 **DO NOT** automatically enroll you in the 2023 plan year. Health FSA contributions are limited to **$2,160** per person in 2023, and DCAP contributions to $5,000 per year, per eligible family.

⇒ If you wish to change medical plans, add or drop dependents from your current medical, dental or vision coverage, all changes must be completed and received by the deadline of **Friday, October 14, 2022**. All required forms and supporting documentation must be received by Human Resources by that same deadline; otherwise, the changes may not be processed.

⇒ If you **DO NOT** have any changes to your current medical, dental or vision plans, your current medical plan elections will continue into the 2023 plan year, **and no further action is required**.

⇒ If you **DO NOT** plan to enroll or re-enroll in a Flexible Spending and/or Dependent Care Account (FSA Plans) for Plan Year 2023, **no further action is required**.

QUESTIONS? Contact Noreen Griffin via email at ngriffin@rgs.ca.gov OR
by telephone: 650-587-7300, Ext. 88.

CHANGES MADE DURING OPEN ENROLLMENT GO INTO EFFECTIVE JANUARY 1, 2023

WHO CAN YOU COVER ON YOUR HEALTH BENEFITS?

Member Eligibility

Coverage for new full-time employees begins on the 1st of the month following date of hire.

After that, Open Enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event.

IT IS IMPORTANT to notify Human Resources within 30 days if you have a qualifying life event and need to add or drop dependents outside of Open Enrollment. Life events include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage or divorce

Who Is Eligible?

In general, full-time and part-time employees are eligible for the benefits outlined in this overview. In order to comply with the Affordable Care Act (ACA), the City of Marina determines your eligibility for medical coverage based on the number of hours you work each month.

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse).
- Your domestic partner is eligible for coverage if you have completed a Domestic Partner Affidavit. Please review the affidavit guidelines. The Cost of Coverage section explains the tax treatment of domestic partner coverage.
- Your children (including your domestic partner's children):
    - Under age 26 are eligible to enroll in medical coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
    - Over age 26 **ONLY** if they are incapacitated due to a disability and primarily dependent on you for support.
    - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

Who Is Not Eligible?

Family members who are NOT eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.
- Any individual who is covered as an employee of City of Marina cannot also be covered as a dependent.
- Employees who work fewer than 20 hours per week, temporary employees, contract employees, or employees residing outside the United States.

NOTE: Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

Outside of Open Enrollment, When Can You Make Changes To Your Benefits?

Other than during the annual Open Enrollment period, you may **NOT** change your coverage unless you experience a qualifying life event. Two (2) rules apply to making changes to your benefits during the year:

1. Any changes you make must be consistent with the change in status, AND you must make the changes within 30 days of the date the event (marriage, birth, etc.) occurs.
2. Mid-year changes are effective the first of the month following the event, if proper notification is provided to Human Resources within 30 days.

During Open Enrollment you can:

⇒ Enroll or change your benefit plan elections
⇒ Enroll in a health plan if you don't currently have coverage
⇒ Cancel your current health coverage
⇒ Add or remove dependents
⇒ Enroll or Re-Enroll in the Flexible Spending Accounts (FSAs) – Health FSA and Dependent Care

Qualifying Life Events Include:

- **Change in legal marital status**, including marriage, divorce, legal separation, annulment, dissolution of domestic partnership, and death of a spouse.
- **Change in number of dependents**, including birth, adoption, placement for adoption, or death of a dependent child (including stepchildren).
- **Change in employment status** that affects benefit eligibility, including the start or termination of employment by you, your spouse or your dependent child.
- **Change in work schedule**, including an increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment that affects eligibility for benefits.
- **Change in a child's dependent status**, either newly satisfying the requirements for dependent child status or ceasing to satisfy them.
- **Change in your health** coverage or your spouse's coverage attributable to your spouse's employment.
- **Change in an individual's eligibility for Medicare or Medicaid**.
- **A court order** resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child or dependent foster child.
- **An event that is a qualifying life event under the Health Insurance Portability and Accountability Act (HIPAA)**, including acquisition of a new dependent or spouse, or loss of coverage under another health insurance policy or plan, if the coverage is terminated because of:
  - Voluntary or involuntary termination of employment or reduction in hours of employment or death, divorce, or legal separation.
  - Termination of employer contributions toward the other coverage, OR if the other coverage was COBRA Continuation Coverage, exhaustion of the coverage.
- **An event that is allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act.** Under provisions of the Act, employees have 60 days after the following events to request enrollment:
  - Employee or dependent loses eligibility for Medicaid (known as Medi-Cal in CA) or CHIP (known as Healthy Families in CA).
  - Employee or dependent becomes eligible to participate in a premium assistance program under Medicaid or CHIP.

If you must make mid-year changes to your health insurance such as adding or removing dependents, contact Human Resources and provide supporting documents **within 30 days of the change of status**.

Enrollment and Required Documentation.

All employees adding/removing dependents must submit documentation to Human Resources to verify their dependent's eligibility and/or Qualifying Life Event. For assistance, please contact Human Resources at **831-884-1283**. Required documentation must be submitted by the deadlines listed in this guide. Late documentation and enrollment and change forms may not be processed.

If you are concerned because you cannot obtain all the needed documentation, please notify Human Resources immediately to discuss. The chart below is an easy guide to determine which documents are required.

You are responsible for ensuring that the health enrollment information about you and your family members is accurate, and for reporting any changes in a timely manner. If you fail to maintain current and accurate health enrollment information, you may be liable for the reimbursement of health premiums or health care services incurred during the entire ineligibility period.

⇒ Dependent children verification includes birth or adoption certificate and social security number.
⇒ Proof of marriage must be a state issued marriage license or marriage certificate (not a church issued certificate) that includes the date of your marriage.
⇒ State Registration Certificate is required for Domestic Partnership.
⇒ Affidavit of Parent-Child Relationship is required for eligible Parent-Child relationships.
⇒ Birth Certificates must be state issued (not hospital issued).

SCENARIO	HOW TO ENROLL	IMPORTANT TIMELINES
Marriage or Domestic Partner	To enroll a new spouse or domestic partner and eligible children of a spouse or partner you must submit the following: * Appropriate application forms * Copy of the marriage certificate or certificate of state registered domestic partnership * Copy of social security card * birth certificate for each child	Required documentation must be submitted to RGS within 30 days of the legal date of the marriage or partnership
Birth or Adoption	To enroll your newborn or newly adopted child, you must submit the following: * Appropriate application forms * Copy of the birth certificate or adoption documentation	Required documentation must be submitted to RGS within 30 days of the legal date of the child's date of birth or placement of adoption
Legal Guardianship or Court Order	Coverage for a child under legal guardianship is effective the date guardianship takes effect, if all documentation is submitted by the 30-day deadline. Coverage per court order will be effective the date of court order, if all documentation is submitted by the 30-day deadline.	Required documentation must be submitted to RGS within 30 days of the effective date of court order
Loss of Other Health Coverage Coverage can be lost due to termination of employment, change from full-time work to part-time work, dropping other employer coverage during Open Enrollment, ineligibility for Medicare or Medicaid, unpaid leave of absence or return from military service	Employees and eligible dependents who lose other coverage may enroll by submitting the following: * Appropriate application forms * Proof of loss of coverage * documentation of lost coverage must state the date other coverage ends and the names of individual losing coverage.	Required documentation must be submitted to RGS within 30 days of the date other coverage terminates

BENEFIT SUMMARY

What can these benefits do for me?

The products in this benefit plan were selected with you and your family's well-being in mind. They're an important part of your compensation package. Please take the time to review the benefits carefully to be sure you select the plans that best fit your needs.

You can learn more about these benefits and how to choose the coverage that's right for you on the following pages. Because these products are offered through your employer, premium rates may be more competitive than similar products you could purchase as an individual.

Eligible employees are offered medical coverage options through CalPERS Region 1 and Region 2 plan areas. To verify that your medical plan is available in your County, please review the CalPERS 2023 Health Plan Summary, Page 6.

Medical Plans

MEA, MMEA, MPFFA Bargaining Units — The following CalPERS medical plan options are offered to employees in the preceding bargaining units: *Anthem Blue Cross Select HMO*, *Blue Shield Trio HMO*, *PERS Gold* and *PERS Platinum*.

Directors, MPSMA — The following CalPERS medical plan options are offered to employees in the MPSOA bargaining unit: *Anthem Blue Cross Select HMO*, *Blue Shield Trio HMO*, *PERS Gold*, *PERS Platinum* and *PORAC*.

POA — The following CalPERS medical plan options are offered to employees in the MPSOA bargaining unit: *Anthem Blue Cross Select HMO*, *Blue Shield Trio HMO*, *Kaiser HMO*, *PERS Gold*, *PERS Platinum* and *PORAC*.

Medical Allowance

The City offers a health plan allowance to offset the cost of health premiums to eligible employees in the following Bargaining Units:

$575 per month ($287.50 per pay period) — **DIRECTORS** and **MPSMA**
$541 per month (270.50 per pay period) — **MEA**, **MMEA**, **MPFFA** and **MPSOA**

Eligible employees receive the health plan allowance in their regular pay period cycles.

HEALTH PLAN PREMIUM RATES

The medical, dental and vision premium rates per bargaining unit are outlined on the following pages and show the total premium cost and the employee's costs for each of the medical benefits offered.

In general, employees pay for health coverage before federal, state and social security taxes are withheld so less taxes are paid.

NOTE: Unless your domestic partner is your tax dependent as defined by the IRS, contributions are required to be taken after-tax. Similarly, the City's contribution towards your domestic partner and his/her dependents will be reported as taxable income on your W-2. It is important that you contact your tax advisor for more details on how this treatment applies to you. Please notify Human Resources if your domestic partner is your tax dependent.

On the Following Pages
Each Bargaining Unit's
Health Plan Allowance,
Medical, Dental and Vision Premiums
And
Employee Contributions Are Reflected
For Plan Year 2023

2023 CALPERS MEDICAL PREMIUMS

Bargaining Units		EE Only	EE + 1	Family
	PERS Platinum			
Director Employee Group MEA Employee Group MMEA Employee Group MPSMA Employee Group MPFFA Employee Group	Monthly	$1,200.12	$2,400.24	$3,120.31
	Less City Portion	($577.93)	($1,155.85)	($1,502.61)
	Emp. Monthly	$622.19	$1,244.39	$1,617.70
	Bi-Monthly	**$311.10**	**$622.19**	**$808.85**
	Anthem Blue Cross HMO Select			
Director Employee Group MEA Employee Group MMEA Employee Group MPSA Employee Group MPFFA Employee Group MPSMA Employee Group	Monthly	$1,128.83	$2,257.66	$2,934.96
	Less City Portion	($577.93)	($1,155.85)	($1,502.61)
	Emp. Monthly	$550.90	$1,101.81	$1,432.35
	Bi-Monthly	**$275.45**	**$550.90**	**$716.17**
	Blue Shield Trio HMO			
Director Employee Group MEA Employee Group MMEA Employee Group MPFFA Employee Group MPSMA Employee Group	Monthly	$888.94	$1,777.88	$2,311.24
	Less City Portion	($577.93)	($1,155.85)	($1,502.61)
	Emp. Monthly	$311.01	$622.03	$808.63
	Bi-Monthly	**$155.51**	**$311.01**	**$404.31**
	PERS Gold			
Director Employee Group MEA Employee Group MMEA Employee Group MPFFA Employee Group MPSMA Employee Group	Monthly	$825.61	$1,651.22	$2,146.59
	Less City Portion	($577.93)	($1,155.85)	($1,502.61)
	Emp. Monthly	$247.68	$495.37	$643.98
	Bi-Monthly	**$123.84**	**$247.68**	**$321.99**
	PORAC - Police Only			
Director Employee Group MPSMA Employee Group	Monthly	$825.00	$1,875.00	$2,300.00
	Less City Portion	($577.93)	($1,155.85)	($1,502.61)
	Emp. Monthly	$247.07	$719.15	$797.39
	Bi-Monthly	**$123.54**	**$359.57**	**$398.69**

MONTHLY HEALTH ALLOWANCE	BARGAINING UNITS
$575	**DIRECTORS**
$541	**MEA** (Miscellaneous Employee Group)
$541	**MMEA** (Management – Non-Sworn Employee Group)
$541	**MPFFA** (Fire Safety Group)
$575	**MPSMA** (Management – Sworn Employee Group)

2023 CALPERS MEDICAL PREMIUMS – POA EMPLOYEE GROUP

Bargaining Unit	*PERS Platinum*			
		EE Only	**EE + 1**	**Family**
POA Employees	Monthly	$1,200.12	$2,400.24	$3,120.31
	Less City Portion	($739.00)	($1,372.00)	($1,585.00)
	Emp. Monthly	$461.12	$1,028.24	$1,535.31
	Bi-Monthly	**$230.56**	**$514.12**	**$767.66**
	PERS Gold			
	Monthly	$825.61	$1,651.22	$2,146.59
	Less City Portion	($739.00)	($1,372.00)	($1,585.00)
	Emp. Monthly	$86.61	$279.22	$561.59
	Bi-Monthly	**$43.31**	**$139.61**	**$280.80**
	Anthem Blue Cross HMO Select			
	Monthly	$1,128.83	$2,257.66	$2,934.96
	Less City Portion	($739.00)	($1,372.00)	($1,585.00)
	Emp. Monthly	$389.83	$885.66	$1,349.96
	Bi-Monthly	**$194.92**	**$442.83**	**$674.98**
	Blue Shield Trio HMO			
	Monthly	$888.94	$1,777.88	$2,311.24
	Less City Portion	($739.00)	($1,372.00)	($1,585.00)
	Emp. Monthly	$149.94	$405.88	$726.24
	Bi-Monthly	**$74.94**	**$202.94**	**$363.12**
	Kaiser			
	Monthly	$913.74	$1,827.48	$2,375.72
	Less City Portion	($739.00)	($1,372.00)	($1,585.00)
	Emp. Monthly	$174.74	$455.48	$790.72
	Bi-Monthly	**$87.37**	**$227.74**	**$395.36**
	PORAC			
	Monthly	$825.00	$1,875.00	$2,300.00
	Less City Portion	($739.00)	($1,372.00)	($1,585.00)
	Emp. Monthly	$86.00	$503.00	$715.00
	Bi-Monthly	**$43.00**	**$251.50**	**$357.50**

DENTAL & VISION PREMIUM RATES

2023 DENTAL PREMIUMS

Bargaining Units	Premier Access			
Director Employee Group MEA Employee Group MMEA Employee Group MPSMA Employee Group		EE Only	EE+1	Family
	Monthly	$40.00	$80.00	$99.00
	Less City Portion	($9.67)	($24.00)	($29.00)
	Emp. Monthly	$30.33	$56.00	$70.00
	Bi-Monthly	**$15.17**	**$28.00**	**$35.00**
Bargaining Unit	**Premier Access**			
POA Employee Group	Monthly	$40.00	$80.00	$99.00
	Less City Portion	($40.00)	($74.00)	($89.00)
	Emp. Monthly	$0.00	$6.00	$10.00
	Bi-Monthly	**$0.00**	**$3.00**	**$5.00**

2023 VISION PREMIUMS

Bargaining Units	VSP Vision Service Plan			
Director Employee Group MMEA Employee Group MPSMA Employee Group		EE Only	EE + 1	Family
	Monthly	$22.81	$22.81	$22.81
	Less City Portion	($20.00)	($20.00)	($20.00)
	Emp. Monthly	$2.81	$2.81	$2.81
	Bi-Monthly	**$1.41**	**$1.41**	**$1.41**

Bargaining Units	VSP Vision Service Plan			
MEA Employee Group MPFFA Employee Group		EE Only	EE + 1	Family
	Monthly	$22.81	$22.81	$22.81
	Less City Portion	($22.82)	($22.81)	($22.81)
	Emp. Monthly	$0.00	$0.00	$0.00
	Bi-Monthly	**$0.00**	**$0.00**	**$0.00**

Bargaining Units	VSP Vision Service Plan			
POA Employee Group		EE Only	EE + 1	Family
	Monthly	$22.81	$22.81	$22.81
	Less City Portion	($15.00)	($15.00)	($15.00)
	Emp. Monthly	$7.81	$7.81	$7.81
	Bi-Monthly	**$3.91**	**$3.91**	**$3.91**

LIFE INSURANCE

CITY PAID LIFE INSURANCE & EMPLOYEE VOLUNTARY LIFE & AD&D INSURANCE

Employee Bargaining Groups	Type of Coverage	Employee Coverage – Employer Paid
DIRECTORS	Life Insurance	**$100,000**
MPSMA	Life Insurance	**$100,000**
MEA	Life Insurance	**$30,000**
MMEA	Life Insurance	**$50,000**
MPFFA	Life Insurance	**$30,000**
POA	Life Insurance	**$15,000**

Additional Coverage Voluntary Life Insurance and AD&D				
DIRECTORS	**Employee Cost**	**$15,000**	**$35,000**	**$50,000**
	Monthly	$9.30	$21.70	$31.00
	Less City Portion	$0.00	$0.00	$0.00
	Emp. Monthly	$9.30	$21.70	$31.00
	Bi-Monthly	**$4.65**	**$10.85**	**$15.50**
MPSMA MEA MMEA MPFFA POA	**Employee Cost**	**$15,000**	**$35,000**	
	Monthly	$9.30	$21.70	
	Less City Portion	$0.00	$0.00	
	Emp. Monthly	$9.30	$21.70	
	Bi-Monthly	$4.65	$10.85	
		$4.65	**$10.85**	

PREMIER ACCESS DENTAL PPO PLAN

Regular visits to your dentists can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

The City of Marina PPO Plan 2-124

Looking For An ID Card?

If you've been looking for your dental plan ID card, the good news is that you don't need one! Just tell your dental office that you are covered by Premier Access provide your name, your date of birth, your enrollee ID number (or social security number), and the name of your employer. If you have dependents on your plan, they will need to provide your details.

If you prefer to have an ID card, you can call their Member Services number at 888-715-0760 or print one from online by logging into your Premier Access dental plan at www.premierlife.com.

Tips On Maximizing Your Dental Benefits.

Your Premier Access Dental PPO plan is a national carrier and widely accepted dental plan.
What is important to know about your dental plan is that you may see any dentist.

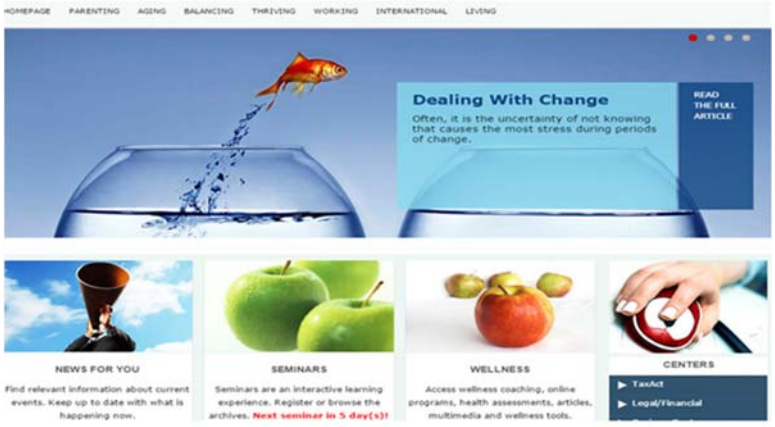
Although, there are PCN (Premier Choice Network) and PPO provider lists available, and the benefits are enhanced if you elect to use either network, you may elect to see the dentist of your choice without penalty. Using the PCN or PPO providers, you maximize your benefits and reduce your out-of-pocket costs.

The PPO dentists offer discounted care (about 30%) and the plan normally pays a higher level of benefit when using an in-network provider. Additionally, the PCN/PPO dentist cannot "balance bill" you for amounts greater than the contracted rate.

** Verify that your dentist is a contracted Premier Access PPO network dentist before each appointment.

CONCERN's EMPLOYEE ASSISTANCE PROGRAM (EAP)

Employee assistance programs provide free confidential services to eligible employees and their family members that can help balance work and life challenges. Consultants are available to assist you 24/7, 365 days a year.



Concern's Member phone number is 800-344-4222 or visit our Member website at employees.concernhealth.com; register with Company Code ***MBASIA****.*

As an employee, you are eligible for EAP benefits. Your EAP can help you in more ways than you realize!

Also eligible:

⇒ Your spouse or domestic partner	⇒ Your dependent child or children

At no cost to you, your EAP can help you with:

⇒ Legal or financial problems	⇒ Caregiving responsibilities
⇒ Grief	⇒ Emotional problems
⇒ Stress	⇒ Marital or family conflict
⇒ Drug or alcohol problems	⇒ Other addictive behaviors

FLEXIBLE SPENDING ACCOUNTS (FSA)

A flexible spending account is a tax-advantaged account that allows you to use pre-tax dollars to pay for qualified medical (Health FSA) or dependent care (DCAP) expenses. During Open Enrollment, you choose how much money you want to contribute to an FSA for the calendar year. You will be able to access these funds throughout the year for qualified expenses. Both the City's Health FSA and DCAP plans are administered by ***Discovery Benefits***. When you participate in an FSA plan via salary reduction, you reduce your federal, FICA, social security, Medicare (and in some cases, state) taxes and increases take-home pay. The money that is deposited into your FSA comes straight out of your gross pay, therefore reducing your taxes.

Health FSA

This plan allows you set aside pre-tax dollars to help pay for certain out-of-pocket health care expenses such as medical, pharmacy, dental and vision co-payments, other dental and vision care expenses, acupuncture and chiropractic care, and more. For a complete list of eligible health care expenses, see IRS' Publication 502. Contributions are made annually and the City's annual maximum amount is **$2,160**. This plan offers a benefit debit card for your convenience.

Health FSA Rules

- You must re-enroll in FSA plans every Open Enrollment period, if you want to continue this benefit for the upcoming plan year.
- The IRS requires that all FSA purchases be verified as eligible expenses. Sometimes, purchases are automatically verified when you use your card. Other times, ***Discovery Benefits*** will request itemized receipts. Always save your itemized receipts!
- You can receive reimbursements up to the full amount of your annual election regardless of the amount you have already contributed.
- The City's Health FSA contribution is currently limited to **$2,160** per person. This means that you may set aside up to $2,160 for the 2023 calendar year on a pre-tax basis.
- You cannot change FSA contributions during the January to December plan year unless you have a mid-year qualifying life event.

Dependent Care FSA

This plan allows you to set aside pre-tax dollars that can be used to help pay for day care services for eligible dependents such as certified day care, pre-school, day camp, before/after school programs, late pick-up fees, placement fees for a dependent care provider such as an au-pair and qualifying custodial care for dependent adults. For a full list of eligible expenses see IRS' Publication 502.

Dependent Care Assistance Program Rules (DCAP)

- Enrollment is required each year. You must re-enroll in DCAP each year during the Open Enrollment period, if you want to continue this benefit.
- In order to qualify for Dependent Care FSA, the IRS has established the following regulations:
  - An eligible dependent is any child under the age of 13 or a dependent who is physically or mentally incapable of caring for his or her own needs, such as an invalid parent and has the same principal place of abode as you for more than half of the year.
  - If you claim the dependent care credit on your tax return or collect compensation through your Dependent Care FSA, you must report the name, address, and taxpayer identification number of each dependent care provider.
  - DCAP expenses are not eligible if the spouse is a stay-at-home parent.
  - The IRS requires that all DCAP reimbursements be verified as eligible expenses. This includes amounts that reoccur each month.
  - The IRS limits contributions to $5,000 per year per family. This means you may only set aside up to $5,000 in a calendar year in a DCAP FSA on a pre-tax basis.
  - Unlike the health FSA, you may only receive reimbursement from your DCAP account equal to the amount you have actually deposited.
  - You cannot change DCAP FSA contributions during the January to December plan year unless you have a qualifying event. In addition to the standard qualifying event reasons, IRS regulations allow employees to make certain mid-year change to their Dependent Care FSA election (or make a brand-new election), if there is a change to the dependent care "cost or coverage" or if the need for childcare changes. Please contact Human Resources within 30 days to determine available changes.

Enrolling in Health or Dependent Care FSA

When you elect to participate in a Health Care FSA, you elect an annual amount for the plan year. This amount will be deducted from your paycheck evenly over the total number of pay periods on a pre-tax basis to cover your expected out-of-pocket health care expenses for the plan year.

You must re-enroll in Flexible Spending Account(s) each year during the Open Enrollment period, if you want to continue this benefit for the upcoming plan year. To enroll in the Health or Dependent Care Flexible Spending Account(s) benefit, you will need to complete the Discovery Benefits FSA enrollment form located on the City's Benefit website. When completed, return it to Human Resources by dropping it off personally or by mail or email. The effective date for FSAs is **January 1, 2023**. Remember, if you do not complete and submit your enrollment form by **October 14, 2022**, during this year's Open Enrollment period, you will not have an account for 2023.

Determining What Amount to Set Aside

Think about the money you spent on eligible expenses last year, which now includes over the counter medications and other care products reflected on the that are used throughout the year. Also, if you have any upcoming procedures you expect to spend FSA funds on, please be sure it is an eligible expense, and find out the estimated amount you will have to pay to ensure you are not electing more than necessary. Please be sure to review the list of Eligible Expenses when estimating your expenses from last year. Make sure to plan ahead and set those funds aside in an FSA.

Maximum Annual Medical and Dependent Care Amounts

Reimbursement Accounts		
	Medical Care	Maximum $2,160.00 Annual ($90.00 bi-monthly)
	Dependent Care	Maximum $5,000 Annual ($208.34 bi-monthly)

Visit the ***Discovery Benefits*** website at www.discoverybenefits.com for more detailed information about the FSA plans.

457(b) DEFERRED COMPENSATION

Deferred Compensation accounts permit eligible employees, on a voluntary basis, to authorize a portion of salary to be withheld and invested for payment at a later date upon termination or retirement. You have two enrollment options, the Traditional 457 Plan and the Roth 457 Plan.

Under the Traditional 457 Plan neither the deferred amount nor earnings on the investments are subject to current federal or state income taxes. Taxes become payable when deferred income plus earnings are distributed, presumably during retirement when you are in a lower income tax bracket.

The Roth 457 Plan option provides an alternative to pre-tax investing. Roth contributions are considered "after-tax," which means taxes are withheld when you contribute. However, qualified distributions on your contributions plus any earnings are completely tax-free.

Contribution Limits

- ⇒ The normal contribution limit in 2023 for the 457 Plan is $20,500.
- ⇒ Employees aged 50 or older may contribute up to an additional $6,500 for a total of $27,000.

For More Information

The City's Deferred Compensation 457 Plans are offered through Mission Square (formerly ICMA) and Nationwide.

Nationwide— Plan #0040976001—Phone # 1-800-769-4457

Mission Square— Plan #3018841— Phone # 1-800-326-7272

WELLNESS RESOURCES

On this page we are highlighting several resources that are available to you, at no cost, to help you stay mentally and physically healthy!

COVID-19 Vaccines

Information on when and where to get the vaccine is still fluid at this point. To get the latest local information on when you are eligible to get the vaccine and where you can get it, go to myturn.ca.gov.

Flu Shots

According to the CDC, getting a flu vaccine is more important than ever to protect yourself and the people around you from flu, and to help reduce the strain on healthcare systems responding to the COVID-19 pandemic. Learn more by visiting the CDC website here CDC Vaccinations.

Kaiser Members:

If you are enrolled with Kaiser, ask your doctor or nurse during your visit, email your primary doctor or go to kp.org/flu to make an appointment or learn more. Flu shots are available at no cost to Kaiser Members as long as you coordinate through your Kaiser doctor or utilize one of Kaiser's convenient clinics.

Anthem Members

The flu shot is covered under your preventive care benefits at 100% when you go to a health professional in your plan. Contact your primary care doctor to get your flu shot. You can also get it at urgent care facilities, retail health clinics, many pharmacies or walk-in doctors' offices in your plan. Visit anthem.com/ca to find network providers near you.

Routine Preventive Care Exams

Finally, remember to schedule your preventive exams and screenings. There is no charge for qualified preventive care under all of our plans as long as you stay within your plan's network. Talk to your doctor about free preventive screenings.

COMMON BENEFIT DEFINITIONS

MEDICAL

OUT-OF-POCKET COST - A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.
DEDUCTIBLE - The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.
COINSURANCE - After you meet the deductible amount, you and your health plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70% coinsurance, you are responsible for paying your coinsurance share, 30% of the cost.
COPAY - A set fee you pay whenever you use a particular healthcare service, for example, when you see your doctor or fill a prescription. After you pay the copay amount, your health plan pays the rest of the bill for that service.
IN-NETWORK / OUT-OF-NETWORK - Network providers (doctors, hospitals, labs, etc.) are contracted with your health plan and have agreed to charge lower fees to plan members, as negotiated in their contract with the health plan. Services from out-of-network providers can cost you more because the providers are under no obligation to limit their maximum fees. With some plans, such as HMOs and EPOs, services from out-of-network providers are not covered at all.
OUT-OF-POCKET MAXIMUM - The most you would pay from your own money for covered healthcare expenses in one year. Once you reach your plan's out-of-pocket maximum dollar amount (by paying your deductible, coinsurance and copays), the plan pays for all eligible expenses for the rest of the plan year.

PRESCRIPTION DRUG

BRAND NAME - A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs.
GENERIC DRUG - A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor. You generally pay a lower copay for generic drugs.
PREFERRED DRUG - Each health plan has a list of prescription medicines that are preferred based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for nonpreferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

DENTAL

BASIC SERVICES - Dental services such as fillings, routine extractions and some oral surgery procedures.
DIAGNOSTIC AND PREVENTIVE SERVICES - Generally include routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.
MAJOR SERVICES - Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.